PATIENT NAME:	**DARNELL, JEREMY**	DOS: **02/26/2003**
PATIENT NUMBER:	542715	JOB: 169387
PROVIDER:	William M. Gavigan, M.D.	
DOCUMENT TYPE:	IME	
PRACTICE NAME:	Tennessee Orthopaedic Alliance	
CHART LOCATION:	1	

Independent Medical Examination

I was requested to see this 28 year-old man by Todd Powers, Attorney, for an Independent Medical Examination, in reference to injuries occurring on October 15, 2001, March 5, 2002, and August 17, 2002.

He states he first injured his back on October 15, 2001, when he slipped and fell working as a deck hand of a boat, landing flat on his low back. He states he went to the Lourdes Hospital and was diagnosed as having a lumbar strain. He was back to work in a week. He states he continued to have some back pain, but he was doing his work.

On March 5, 2002, he states he slipped on some ice and fell landing on his left knee. He did not fall on his back. He felt a pop in his low back. He was treated at the Western Baptist Hospital emergency room. The medical records of that visit indicate complaints of back pain but normal straight leg raising tests, normal motor testing and sensory exam. He was back to work later in March. The note of March 29, 2002, indicated that he was pain free.

He indicates this episode was severe. He felt numbness in both legs, and was unable to walk. He states he had to be carried up the hill by his fellow workers. The diagnosis was a lumbar strain.

He states he continued to have some intermittent back pain and some pain in his right leg to his knee. He felt he was getting worse. On August 17, 2002, he had similar episode of pain when putting on a face wire. He was taken to the Western Baptist Hospital again. He had a MRI study of the lumbar spine which was unremarkable. X-rays of the lumbar spine were normal. After that he was laid off he states. He has not worked since then.

He started going to the pain management center in Paducah on 8-7-02, ten days before his last report of injury August 17. The history of the initial evaluation indicated that he at first injured his back in April 2001, when he was at home mowing. He felt his back pop. He had instant low back and right leg pain. The right leg became stiff and he was unable to walk. He states he went to Lourdes Hospital emergency room then. He saw Dr. Merriweather and had a CT scan of his lumbar spine. He was told he had a spastic muscle and was off work for a month. He went to physical therapy for 3 weeks.

This evaluation reports that he had a MRI study of the lumbar spine on 8-07-02, which showed L5 degeneration with mild annular bulging and a central annular tear. No

EXHIBIT
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evidence for a lumbar disc herniation. A CT scan of the lumbar spine of 4-16-01, was a normal exam. X-rays of the lumbar spine of 4-16-01, were normal.

He has been treated at the pain clinic since then. He is now having injections in his back every 2 months. He is on pain medications.

He states he has constant back pain. He can walk about 1200 feet at a time. He can sit 15 to 20 minutes at a time. He can't lift more than 20 to 25 pounds. He can't lift his 20-pound child. He is unable to bend. He sleeps off and on. He complains of weakness in his right leg. He states his right leg gives out on him. He states he has numbness in a stocking distribution in both legs from his hips down to his toes. This is always present but intermittent in intensity and numbness.

He states in the last few weeks, he has developed low back pain with sneezing and also associated with pain in his arms.

I reviewed the medical records provided. These include the pain management center records and emergency room reports and hospital reports of Western Baptist Hospital.

Past medical history form reviewed. Otherwise, he has been in excellent health.

Current Medications: Topamax, Vicoprofen, Celexa

ALLERGIES: None

On exam today, this healthy appearing man was walking with mild bilateral waddling gait. He will not walk on his toes and heels because of pain. When standing he shows a tight back with only 10° forward bending and 0° extension. When laying on the examining table, he can sit up and touch his toes with no difficulty, showing full back flexion and normal Straight leg raising tests to 90°. When supine, Straight leg raising tests are 10° right leg, 30° left leg. He has mild decreased sensation in the stocking distribution from his hips to his toes bilaterally. Knee and ankle reflexes 2+. No muscle atrophy in his legs. He can shift weight easily from one foot to the other, showing his back muscles relax as he does this. No evidence of muscle spasm. He has some tenderness in the lower lumbar area.

X-RAYS: no x-rays to review

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DIAGNOSIS: Lumbar strain, by history

There appears to be a functional component to his problem. There are inconsistencies in the exam. He has stocking distribution of numbness in both legs. There was no mention of numbness in his legs in any of the doctors' notes I had to review. Throughout, his neurologic exam had been reported as normal. Of interest, he had significant back problems in April 2001, missing work for about a month.

The physical findings are unremarkable. I would not expect any permanent impairment to result from his injuries occurring at work. Based on his findings, I would believe he should be able to do his regular work and have no restrictions. I do not think he needs further treatment and would recommend he come off his narcotic pain medicine.

His diagnosis for his three incidences could have been lumbar strain.

He has reached MMI from these injuries.

William M. Gavigan, M.D./jb